



## Original communication

## Medical litigation in oral surgery practice: Lessons learned from 20 lawsuits

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## ABSTRACT

The aim of this study was to investigate all the lawsuits related to oral surgery practice over a period of three years, and to analyze the different causes of litigation. Inclusion criteria involved all the closed cases that proved malpractice against an oral and maxillofacial surgeon or involved a dentist who performed an oral and maxillofacial surgical procedure. The most common causes of litigation were orofacial communication, neurological deficit, and bleeding. The study presented the lessons learned from 20 cases, and concluded that most of the lawsuits in oral surgery practice can be prevented either through preoperative measures or by dealing with the impact of the surgical error through good patient rapport and communication

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## 1. Introduction

Medical litigation and patient injury due to surgical intervention are two problems that influence oral surgery practice. Though the scope of oral and maxillofacial surgery is wide, the most common procedures performed by an oral surgeon are dentoalveolar and implant placement.<sup>1</sup>

The two main reasons that patients sue an oral surgeon are injury that results from breaching the standard of care and lack of professional attitude.<sup>2</sup> The standard of care in English tort law is defined as “the degree of prudence and caution required of an individual who is under a duty of care. A breach of the standard is necessary for a successful action in negligence.”<sup>3</sup>

The literature shows that oral surgery procedures carry variable degrees of risk to patients. Implant placement in the posterior mandible carries minor risk of injury to the mental and inferior alveolar nerves (0.08%).<sup>4,5</sup> In wisdom teeth surgery, the risk of injury to the inferior alveolar nerve or lingual nerve ranges from 2.7 to 36% and 0.25 to 23%, respectively.<sup>6–11</sup> In a bilateral sagittal split

osteotomy, this risk rises to 55.7 % at the chin and 27.3 % at the lip in the immediate postoperative period.<sup>12</sup>

Although the General Medical Council of the U.K. released guidelines about the required information that should be given to patients during the consent process, there are still variations among practicing surgeons.<sup>13</sup> Complications, such as pain, swelling, trismus, bleeding, infection, damage to other teeth, and temporary or permanent nerve damage, are considered indicators for the outcomes of different surgical procedures.<sup>14</sup>

Failures to explain these risks before surgery or to get the patient involved in the decision-making process are predictors of a lawsuit.

In the U.S.A., Lee et al.<sup>15</sup> found that the main malpractice claims reported by one insurance company were paraesthesia following third molar extractions and implant placement, infection, and wrong-site tooth extraction. In Spain, Perea et al.<sup>16</sup> stated that more claims were filed related to implant placement than all other oral surgery procedures. In Iran, extraction of the wrong tooth, inappropriate procedure, and errors resulting in paraesthesia were the most common claims in oral surgery lawsuits.<sup>17</sup>

In the U.K., the total amount of settlements paid out by the National Health Service for oral and maxillofacial surgery litigation over 15 years was in excess of £5 million.<sup>18</sup>

Because medical litigation places an extra cost on the delivery of medical services, it has become essential to perform an analysis of all lawsuits related to oral surgery practice to determine the most common causes.

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## 2. Materials and methods

This was a retrospective, descriptive study that investigated all lawsuits that were recorded over a period of three years (2009–2012) in the Eastern Province of Saudi Arabia. Inclusion criteria were all closed cases that proved malpractice against an oral and maxillofacial surgeon or involved a dentist who performed an oral and maxillofacial surgical procedure. All case files were retrieved from the Ministry of Health after getting approval from the Legal Health Commission. All cases were analyzed for the following information.

- Age of the plaintiff.
- Type of procedure involved.
- Type of injuries or damages.
- Type of health care centre where the medical service was provided.
- Amount of money awarded by the jury.

## 3. Results

One hundred lawsuits were investigated; only 20 cases fulfilled the inclusion criteria. Sixteen cases occurred in the private sector, while 4 cases occurred in government hospitals. Seventeen cases were filed against general dentists, while 3 cases were filed against oral and maxillofacial consultants. All but one of the lawsuits involved adult patients.

The most common cause for litigation was oro-antral communication, followed by neurological deficit associated with the surgical removal of wisdom teeth and placement of dental implants (Table 1).

Bleeding after extraction was the third most common cause for litigation; although the problem occurred as a result of dental treatment, other doctors involved in the treatment were found to be responsible for the damage.

All 20 cases showed a lack of professionalism in communication, documentation, breach of privacy, or lack of informed consent.

The total amount of compensation for the 20 cases was \$200,000. The highest amount a jury awarded was \$50,000, which was compensation for a patient who had lost vitality of anterior teeth and had bone necrosis in the anterior maxilla following orthognathic surgery.

## 4. Discussion

The aim of the study was to analyze and report the different reasons for lawsuits in oral surgery practice. All medical practitioners are at a risk of lawsuits, which puts a strain on the surgical

team and reduces job satisfaction.<sup>19</sup> Identifying and learning from medical errors are two effective strategies in risk management.

Medical errors, patient safety, and lawsuit claims are interrelated in medical practice. Lang concluded that improving patient safety could reduce malpractice rates, which reduces the risk of having lawsuits filed against practitioners.<sup>20</sup>

### 4.1. Lesson 1

The present study showed that the majority of clinical claims were related to regurgitation of fluid through the nose due to oro-antral communication following tooth extraction. Analysis of the reasons why these claims were brought against practitioners showed three common factors. Most practitioners were general dentists doing a simple extraction for a maxillary tooth without obtaining informed consent for the possibility of facing a surgical procedure. The concluding statement in all of these lawsuits, which went against the dentists, was “Failure to meet the standard of care based on inability to identify the risk before treatment, and negligence during surgery”.

Surgeons often focus on having the patient signature on the consent form and neglect to explain the practical consequences of the operation; the patients, in turn, tend not to inquire about possible complications.<sup>21</sup> In the U.S.A. in 1979, the National Institutes of Health recommended that patients should be informed of potential surgical risks, including any permanent condition with an incidence higher than 0.5% or any transitory condition with an incidence of 5% or more.<sup>22</sup>

### 4.2. Lesson 2

The second most common claim was neurological deficit following wisdom teeth extraction or implant placement. Although all of the cases involved patients who consented for such complications, the court decision went against the surgeons for three reasons. First, there was a breach in the standard of care due to improper risk assessment before surgery. The procedure was being performed in close proximity to the inferior alveolar nerve, and the surgeon did not make the necessary preoperative preparations, such as obtaining a cone beam CT. Johnson stated that the surgeon should focus on determining whether advanced studies are warranted in preparing for a case, because it could be argued that preparation in every case requires a dental scan or CT scan.<sup>23</sup>

The second factor was negligence during surgery, which occurred when the surgeon removed an unjustified amount of bone. The third was related to the consenting and documentation processes. The patients were not involved in the decision-making process and had not been offered the option of no treatment. Inappropriate operative notes confirmed these findings.

Holmes and Udey stated that brief chart notes, which are not up to legal standards, allow the plaintiff's attorney to ‘paint’ a picture of the patient's care that implies substandard treatment.<sup>2</sup>

The above-mentioned factors confirm that the consenting process doesn't protect a negligent surgeon who delivers a suboptimal standard of care.

### 4.3. Lesson 3

The third most common cause for lawsuits was persistent bleeding after extraction due to improper preoperative and post-operative management. Although one of the cases was filed only against a dentist, both the dentist and the physician who provided consultation received a penalty. The physician did not provide clear, comprehensive instructions when consulted for a patient who was on Warfarin. There was another claim by a patient who had loss of

**Table 1**  
Lawsuits in oral surgery practice.

Surgical procedure	Main complain	Number of cases
Teeth extraction	Oro-antral communication	6
	Persistent bleeding	2
	Wrong tooth extraction	1
	Brain death	1
Surgical removal of impacted teeth (lower wisdoms and upper canines)	Neurological deficit	4
	Fracture mandible	2
	Injury to adjacent teeth	1
Dental implant placement	Neurological deficit	1
	Failure of surgical phase.	1
Orthognathic surgery	Bone necrosis, and loss of teeth vitality	1

vitality of upper lateral incisor following surgical removal of a palatally impacted canine. Although the patient consented for such a complication, the court decided against the dentist. The court concluded that the procedure was not within the scope of practice of a general dentist. Both cases represent a failure to obtain an expert opinion and miscommunication between specialties. This could provide an explanation why the filed cases in private practice were more than those in governmental hospitals. Getting compensated per case in private practice might be a reason for a general dentist to perform procedures that are beyond his or her scope.

Church reported that the main cause of malpractice suits is the doctor's failure to make adequate and prompt referral when confronted with a problem that is beyond his or her diagnostic and technical ability. As a result, patients could claim for punitive as well as compensatory damages.<sup>24</sup>

#### 4.4. Lesson 4

The most serious complication in our study occurred when a patient had brain death following tooth extraction due to a delay in emergency management. The surgeon was found responsible due to improper postoperative handling of a cardiac patient. Following successful simple extraction, the patient became very anxious and developed shortness of breath, gasping, and then lost consciousness. The surgeon preferred to immediately transfer the patient by wheelchair from the dental office to the emergency room, which was 5 min away in the same hospital. The court concluded that although the surgeon intended to save the patient's life, this effort did not clear him from being negligent. The court decided that the surgeon did not follow the guidelines, which stress the necessity of requesting help, activating the right code, and providing basic life support until help arrives.

#### 4.5. Lesson 5

The majority of the cases involved a lack of communication and rapport between the surgeon and patient, either during the consenting process or after the complication. Gulati et al.<sup>18</sup> stated that many claims arise because the process of obtaining patient consent is poor. The authors concluded that both verbal and written communication is essential during the consenting process. This conclusion was in agreement with Krause et al.,<sup>21</sup> who found that a considerable proportion of lawsuits originate from misunderstandings, not treatment errors.

Johnson stated that telephone calls to patients and personal notes will do more to benefit your practice than anything else,<sup>23</sup> while Lang described the medical litigation process as a pyramid: on its base, the total number of medical injuries; on the second level, the total number of claims filed; and at the peak of the pyramid, the plaintiffs who win the suit. The author concluded that a physician with good communication skills could prevent a medical error from going from the base of the pyramid to its peak.<sup>20</sup>

Although this theory is a strategy for risk management that addresses the consequences of the accident, our study highlighted the value of preventing the occurrence of the accident through proper patient preparation, seeking of expert opinion, following guidelines, and respecting the scope of practice.

## 5. Conclusion

Most of the lawsuits in oral surgery practice can be prevented either through preoperative measures or by dealing with the impact of the surgical error through good patient rapport and communication.

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